§ 10127.3 Qualified Rehabilitation Representative (QRR).

~~*The provision of v*~~Vocational rehabilitation services under Labor Code Section 4635(d) shall be provided by ~~*individuals who meet the definition of*~~ a ~~*QRR*~~ Qualified Rehabilitation Representative (QRR) as defined in Labor Code Section 4635 (b), except where a QRR Waiver pursuant to Labor Code Section 139.5(a)(2) has been granted. ~~*When*~~ Within 15 days after an employee is determined to be medically eligible and chooses to participate in a vocational rehabilitation program pursuant to Labor Code Section 4637, ~~*within ten days he/she is to*~~ the employee shall be referred ~~immediately~~ to a QRR selected in agreement by ~~*between*~~ the employee and the employer. ~~*claims administrator, pursuant to Labor Code Section 4637.*~~ When the employee is referred to the QRR, the employer shall send all pertinent medical and vocational reports to the QRR. If the employee and the employer cannot agree to ~~*agreement on*~~ a QRR ~~*cannot be reached*~~ within the 15 day time frame, ~~*days*~~ either party may request the Unit to appoint an Independent Vocational Evaluator (IVE). ~~*The referral to the QRR shall include all pertinent and narrative medical and vocational reports to assist the QRR in the evaluation process.*~~

Note: Authority cited: Sections 133, 138.4, 139.5, 5307.3, Labor Code
Reference: Sections 4635, 4637, 4640, Labor Code

§ 10133.12 Form RU-94 "Notice of Offer of Modified or Alternative Work" and Form Filing Instructions

[Form RU-94 and Instructions attached]

Note: Authority Cited: Sections 133, 139.5, and 5307.3, Labor Code
Reference: Sections 4635, 4636, and 4637, Labor Code

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

THIS SECTION COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Employer (name of firm)_____ is offering you the position of a

(name of job) _____.

Attach a list of the duties required of the position.

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____. Date job starts: _____.

Claims Administrator:_____Claim Number:_____

NOTICE TO EMPLOYEE Name of employee: _____

Date offer received: _____

You have 30 calendar days from receipt to accept or reject this offer of modified or alternative work. If you reject this job offer, you will not be entitled to rehabilitation services unless:

Modified Work

A. The proposed modification(s) to accommodate required work restrictions are inadequate.
B. The modified job will not last 12 months.

Alternative Work

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered were less than 85% ~~of the wages~~ paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

__ I accept this offer of Modified or Alternative work.

__ I reject this offer of Modified or Alternative work and understand that I am not entitled to vocational rehabilitation services.

_____ Date _____

Signature

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

~~**All employees must present documents required for completion of *INS Form I-9* prior to starting modified or alternative work.**~~

The employer or claims administrator must forward a completed copy of this agreement to the Rehabilitation Unit with a Notice of Termination (DWC Form RU-105) within 30 days of acceptance or rejection.

If a dispute occurs regarding the above offer or agreement, either party may request the Rehabilitation Unit to resolve the dispute by filing a Request for Dispute Resolution (DWC Form RU-103) at the applicable Rehabilitation Unit. The Rehabilitation Unit venue is the same as the Workers' Compensation Appeals Board. If no WCAB case exists, file with a Rehabilitation Unit at ~~within~~ the appropriate district office. ~~county where the injured employee resides.~~

MANDATORY FORMAT
STATE OF CALIFORNIA
DWC-RU-94 (11/21/02)

Rehabilitation Unit
California Division of Workers' Compensation

Form RU-94

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

Purpose:
To document an offer of modified or alternative work by the employer at the time of injury. The form also documents the acceptance or rejection of modified or alternate work by the injured employee. The RU-94 is to be used only for injuries which occur on or after 1-1-94.

Submitted by:
The claims administrator obtains the response of the injured worker and submits the form to the Rehabilitation Unit.

When prepared:
The form is prepared at the time of the offer of modified or alternative work by the employer or claims administrator. This form is not to be used to document a plan for modified or alternate work offered subsequent to advising the worker that modified or alternative work was **not** available.

Where submitted:
Initially to the injured worker within 30 days of the acceptance or rejection of the offer, then it is submitted to the Rehabilitation Unit, together with a RU-105.

Form completion:
The employer or claims administrator completes the information in the top box. The employee completes the section so marked.

Accompanying document:
The RU-94 is submitted with a RU-105 Notice of Termination. The submitted RU-94 must also include a list of duties required of the position and wages offered.

Rehabilitation Unit action:
The Rehabilitation Unit will not take action unless the employee objects by filing a RU-103, Request for Dispute Resolution, to the Notice of Termination.

Note*: ~~Once the offer of employment is made, the employee has 30 days from the date of the offer, to accept or reject the offer.~~* If the offer is not accepted or rejected within 30 days of the offer, *it is ~~assumed~~* the offer is deemed to be rejected by the employee. The employer has the option to file a RU-105, Notice of Termination, or extend the 30-day period by mutual agreement.